REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **This report is being sent to:** [redacted] Operations Director, Human Race Limited, Unit 6, Typhoon Business Centre, Oakcroft Road, Chessington, KT9 1RH
1	**CORONER** Christopher P Dorries OBE, HM Senior Coroner for South Yorkshire (West)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION** In May 2017 I commenced an investigation into the death of Mr David Worthington. The investigation concluded following an inquest in July/August 2018 where the narrative conclusion set out that: *Mr Worthington suffered fatal injuries whilst taking part in a Cycling Sportif event on the 30th April 2017. He had travelled down the lengthy descent of Finkle Street Lane at Wortley and, like other riders, was most probably travelling at about 30-35 mph. As he rounded a limited visibility bend he was confronted by a 12 metre coach turning right out of Plank Gate. The visibility was limited for both cyclist and coach driver. Mr Worthington braked hard and attempted to miss the vehicle but was unable to do so.*
4	**CIRCUMSTANCES OF THE DEATH** See narrative conclusion above and the detailed findings of the inquest previously supplied. A copy of my decision document is attached for those who have not previously had sight of it.

5	**CORONER'S CONCERN** During the course of the investigation my inquiries revealed matters giving rise to a concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows -- a) The risk assessment prior to the event had not identified the particular location as a risk. In many ways this is understandable, Plank Gate is a minor junction. b) However, more detailed consideration might be thought to show a different picture. There were 2900 cyclists progressing swiftly down a lengthy descent into a blind bend. The organisers efforts in putting a 'slow' sign part way down the descent were, on the evidence of witnesses, largely ignored. c) Plank Gate is the entrance to a moderately busy riding school and hacking centre. Sunday morning is a common time for such activities. d) Whilst the risk of a vehicle leaving Plank Gate across the path of fast-moving cyclists might reasonably have been considered low, the other element of a risk assessment is the likelihood of injury if such an event did occur. The risk of harm, as identified by this collision was extremely high. e) It is accepted that the route of this prestigious and worthwhile event changes regularly so that Finkle Street lane is unlikely to be used again. Nonetheless, in my respectful submission there is room for a review of the risk assessment methods used for future events. As this incident shows, unlikely events can and do occur and where the risk of harm is high proper consideration is essential.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the named organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th October 2018. I may extend this period upon request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the family of Mr Worthington and their solicitors. Copies have also been sent to the Barnsley MBC and the legal representatives of Skill Coaches Ltd I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

29. Aug. 18